## **Appendix 20e • Client's Physicians and Other Health Professionals (Optional)**

Client's Last Name	First Name		MI	MSSP #	
NAME:	MSSP	1	2	3	4
SPECIALTY:	Assessment  Date Last				
ADDRESS:	seen by HP?				
PHONE:	MSSP Assessment	5	6	7	8
MEDI-CAL PAYS?	Date Last seen by				
□ Yes □ No	HP?				
NAME:		1	2	3	1 4
INAIVIE.	MSSP Assessment	'	2		4
SPECIALTY:	Date Last seen by				
ADDRESS:	HP?				
PHONE:	MSSP Assessment	5	6	7	8
MEDI-CAL PAYS?	Date Last				
□ Yes □ No	seen by HP?				
		1			
NAME:	MSSP Assessment	1	2	3	4
SPECIALTY:	Date Last				
ADDRESS:	seen by HP?				
PHONE:	MSSP Assessment	5	6	7	8
MEDI-CAL PAYS?	Date Last				
□ Yes □ No	seen by HP?				

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